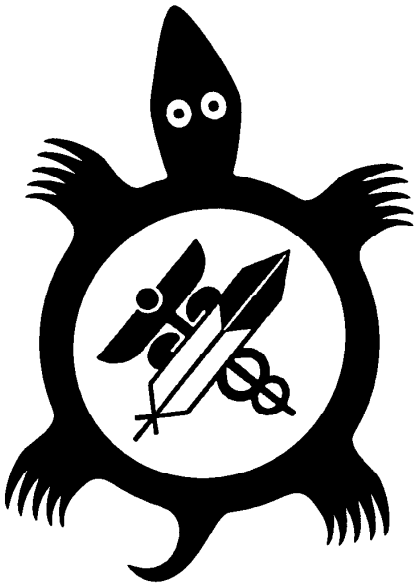
Public Health Support

Workgroup Report

September 1, 1999



Final Report

The full Public Health Support Workgroup report will be available through the IHS Home Page on the Web at www.ihs.gov after December 1, 1999.

PUBLIC HEALTH SUPPORT WORKGROUP
FINAL REPORT

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To the Executive Leadership Group
June 4, 1999
(Revised September 1, 1999)

Public health is an essential and, at least to a small degree, a residual function for the Indian Health Service (IHS). It represents an organized process that promotes physical, emotional, social, and spiritual health to prevent disease, injury, and premature death. Public health requires an integrated framework that guides the development and maintenance of an adequate public health infrastructure. The framework provided by the Public Health Support Workgroup (PHSWG or the Workgroup) defines the core public health functions and the essential public health services that are relevant for all local, regional, and national service levels, functions which are necessary for continued improvement in the health status of Indian people and communities.

It is imperative that a national public health presence continues, and that it be enhanced in specific functions. However, the traditional model of finding solutions for local problems at a national level is no longer valid, nor is the belief that any national function in Indian public health can only be provided by IHS. IHS, tribes, or Indian organizations possessing the necessary competencies could carry out the majority of the national functions. Regardless, adequate resources need to be preserved for these purposes, even with additional assistance from other entities.

The Executive Leadership Group gave the PHSWG five charges. The first two charges required the identification of an appropriate model to ensure continuation of public health services to direct, compacted and contracted tribal organizations. The PHSWG created a matrix of public health responsibilities to be carried out at the local, regional and national service levels that address essential public health services. This matrix was based upon the ten essential public health services identified by the DHHS Public Health Functions Steering Committee. The PHSWG recommends that these defined responsibilities be met at their respective levels.

The maintenance of a national public health infrastructure is a critical element in the Workgroup's response to charges one and two. Using the above mentioned matrix, the PHSWG identified the necessary national services and type of staff to meet each role, as well as a determination of the public health residual. The Workgroup proposes this mix as the absolute minimum staff required to maintain the public health infrastructure at the national level, while recognizing that the IHS remains underfunded to fully carry out its mission and goal. In order not to be misinterpreted, these recommendations must be considered only in conjunction with the assumptions and conditions that accompany them.

The third charge required the identification of critical health data to assess and track public health. If the Agency does not adequately maintain information systems, it will not be able to maintain an effective public health system. Acknowledging the maxim that what gets measured gets done, the PHSWG designed a dynamic data collection model. This model maps the recommended minimal data elements for specific reporting requirements and/or advocacy needs. The Workgroup recommends that this method be used to maintain and update a list of minimal data elements, and serve as a basis to negotiate ongoing reporting agreements with tribes and urban programs. Furthermore, the Workgroup recommends that the responsibility for maintaining this list for all Indian health systems be delegated to the Information Systems Advisory Committee (ISAC).

The fourth charge required development of new models for the delivery of public health services emphasizing collaboration. The PHSWG collected and examined many current programs that are successful in this respect. There are common elements among these varied models. The PHSWG identified some of the similarities that lead to successful implementation of a variety of community-

initiated public health programs. A template is provided in the main report to serve as a guide to maximize the potential success of new programs.

The fifth charge required a process to provide for public health needs within a managed care environment. In order for a managed care program to include a public health perspective, it must have the capability to provide data collection and community driven public health services, in addition to appropriate individual care. If an IHS/Tribal/Urban (I/T/U) managed care program meets these criteria, the I/T/U delivery system can serve as an integrated community-oriented primary care model for the rest of the country. The PHSWG strongly recommends that the Agency maintain and expand its dialogue with the managed care community to promote public health concepts, and that it measure its level of needed funding by taking into account both personal and public health needs.

In December 1998, the Workgroup received an informal request (a sixth charge) from the Indian Health Leadership Council (IHLC) to amplify its original scope by making recommendations to the Internal Evaluation Team (IET) regarding any potentially residual public health functions within IHS Headquarters in a hypothetical 100% self-governance environment. The Indian health care landscape has been changing. Tribes and tribal organizations with new competencies and capabilities will begin to provide certain functions to IHS direct care programs and Area and Headquarters offices, instead of the other way around, including some public health functions. The Workgroup not only welcomes, but also deems as essential, increased tribal and Indian organization leadership in national public health functions. Nonetheless, it was the conclusion of the PHSWG that a small amount of residual public health responsibilities and functions would remain, even in a 100% compacted environment.

The adoption of the PHSWG recommendations throughout the Agency would result in increased organizational public health competency, which should be measured, tracked and reported. Communication of this report, as well as the follow-up actions, is critical to this process. The PHSWG believes that increased sharing of information and “best of practice” models are critical to the public health future of the Indian health care system.

We would like to thank the ELG for this unique opportunity to help influence the future of public health within the Indian health system. We believe that the health status of American Indian and Alaskan Native (AI/AN) communities can and will continue to improve through improved public health competency.

Final Report of the Public Health Support Workgroup
June 1999

The Executive Leadership Group (ELG) of the Indian Health Service (IHS) established the Public Health Support Workgroup (PHSWG) in July, 1998. The creation of a Public Health Support Workgroup reflects the Agency's continued desire to ensure adequate provision of public health support services to American Indians and Alaska Natives (AI/ANs).

I. INTRODUCTION

A. Context and Purpose

IHS has always been a public health agency. This is clear from its institutional beginning as a Bureau of Indian Affairs Health Division, created for "the relief of distress and conservation of health" of American Indians and Alaska Natives (AI/ANs). Its transfer to the Public Health Service of the Department of Health, Education and Welfare, currently the Department of Health and Human Services, has helped ensure its ongoing focus on public health.

In 1995, IHS began an extensive redesign process to help it better adapt to a variety of factors, including rising health care costs, increasing tribal management of programs, and downsizing initiatives in the Federal government. Within this reorganized Agency, a primary focus has remained public health. The Goal of IHS, as recommended by the Indian Health Design Team, is to ensure "that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people."

The ELG presented five charges to the Workgroup.

1. Consistent with the recommendations of the Indian Health Design Team (IHDT), identify essential public health support services to be provided to existing direct service sites. Develop a plan to continue to provide these essential public health services to existing direct service sites for at least the next 3-5 years.
2. Develop a plan showing how IHS can provide public health support services to contracting and compacting tribes who may wish to receive some or all of these services.
3. Identify critical health data necessary for IHS to perform advocacy and other core functions. Develop recommendations on how to assure that IHS can continue to access critical health data from all delivery systems to enable IHS to perform these functions effectively of behalf of all groups served.
4. Develop recommendations for a new model for providing public health services to AI/AN people using a collaborative and integrative approach with other organizations.
5. Develop a plan to assure the provision of adequate public health support within the expanding managed-care environment.

B. Workgroup Membership

To provide the widest possible range of public health experience and opinion, the membership of the Workgroup represented a broad range of points of views, from local, Area (equates to "regional" in this document), and Headquarters levels, as well as IHS and non-IHS individuals:

Chairperson: Dr. Theresa Cullen – Clinical Director, Sells Service Unit
Dr. Eric Broderick – IHS, Office of Public Health, Rockville
Dr. James Cheek – IHS, Office of Public Health, Albuquerque

RADM Richard Church – IHS, Chief Information Officer, Rockville
Dr. Stanley Griffith – IHS, Office of Public Health, Albuquerque
Dr. Clark Marquart – Chief Medical Officer, Portland Area IHS
Ms. Nancy Miller-Korth – Nursing Consultant, Great Lakes Tribal Consortium
Ms. Sherrianne Moore – Ponca Health Center Director
Dr. Doug Peter – Chief Medical Officer, Navajo Area IHS
Ms. Muriel Segundo, Tohono O'Odham Tribe, NIHB representative
Dr. Mary Beth Skupien – IHS, Office of Public Health, Rockville
Ms. Maggie Terrance – St. Regis Mohawk Tribe
Facilitator: Dr. Mary Beth Kinney, Clinical Support Center

(Note: A chronological summary of the Workgroup's meetings, conference calls, and background considerations comprises Appendix A.)

II. ISSUES AND WORKGROUP PERSPECTIVES

A. What Is Public Health?

Public health is what we do as a society to keep people healthy and to assure those conditions in which health can thrive. Scientific and technical knowledge, as well as public values and opinions, affect public health. Recently, there has been an increasing emphasis on the role of society in helping ensure health. Effective public health activities have been recognized as essential to the health of our society, as well as the health of communities, families and individual people.

Successful public health requires a strong infrastructure. This infrastructure must integrate activities throughout national, regional, and local levels, and possess well-developed public health competencies appropriate to each level.

The public health model is more comprehensive than the traditional health care model, which is more focused on the delivery of care to individuals by doctors, nurses, or other healthcare providers. Public health requires a responsibility for those in a community who routinely seek care through the standard health facilities as well as those who do not. To be successful, the public health model must include community outreach to address health promotion and disease prevention, environmental health, and must engender and support community empowerment and partnerships. Public health requires a multidisciplinary team-oriented concept, aimed at the improvement of a community's rather than just an individual's health.

B. Public Health and Indian Health Care

IHS is first and foremost a public health agency. Since its origin in 1955, the Indian Health Service has worked in collaboration with tribal governments, tribal health boards, urban programs, and other organizations to improve the health status of American Indian and Alaska Native (AI/AN) people. Remarkable improvements have been achieved. These improvements have resulted from multiple factors, including changes in delivery systems, increased emphasis on preventive care, and improved public health services provided to communities.

Currently, lifestyle related diseases play a major role in the morbidity and mortality of AI/ANs. The traditional health care delivery system can only have a limited impact on this. However, community initiated programs can have a significant impact on these diseases and indicators of health, if the infrastructure required for their success is established and functional.

As more tribes are operating their own health programs under self-determination, many have maintained a close integration of public health and preventive efforts. In many cases, there is a potential for this

integration to exceed that previously provided by IHS through its direct services. This is due to increased flexibility, the ability to incorporate additional tribal or private sector programs and resources, and different perspectives on community needs and values.

C. Input Concerning Current Capacities

To learn more about the existing public health infrastructure at the various levels of the program, the PHSWG developed three surveys to solicit the impressions of a variety of individuals. The first targeted the local level, and was sent to service unit directors, tribal health directors and urban health directors in each Area (one of each). The second was developed to obtain input from the Area level and was sent to each CMO. The last survey was directed at the headquarters level and was sent to staff within the Office of Public Health. These surveys comprise Appendix B.

Key results:

- The respondents felt the capacity for obtaining public health services from the local and area levels are generally adequate, while Headquarters capacity was inadequate.
- Public health needs to be an area of emphasis within the Agency.
- Not enough resources are devoted to public health.
- "Assure a competent public health and personal health care workforce" was identified by all three surveyed groups as among the most important essential services that I/T/U programs will need access to over the next 3 to 5 years.

Interestingly, our review of previous reports, as well as years of aggregated personal experience within the Workgroup, had led us to similar conclusions. A national public health presence must continue, and it must be enhanced in certain areas. However, the traditional model of finding solutions for local problems at a national level is no longer valid. In addition, the belief that any national function in Indian public health can only be provided by IHS is no longer accurate.

D. Evolving Indian Health Care Landscape

This is an especially challenging time for traditional regional (Area) and Headquarters levels within IHS. It is often unclear how best to maintain the public health nature of the Agency. The transfer of not only many programs, but also associated administrative support functions to tribes, necessitates adjustments. Simultaneously, other factors have resulted in the need to reassess Headquarters functions, including the general trend of downsizing of the Federal government, and shrinking of relative resource levels.

The role of public health agencies is to support work that decreases disease burden and improves health status. These challenges are even more imperative for Indian health systems. The very marked disparity in health status of AI/ANs compared with the general population has continued, as has the ongoing, historical Federal obligation to tribes as a whole with respect to their health care. A viable public health structure can help ensure that this work can be done in an effective manner, by assuring local, regional and community based involvement wherever appropriate.

The era of IHS directly providing most or all required healthcare services to tribal members is clearly over. There is now a mix of providers, collectively referred to as the "I/T/Us" (IHS/Tribal/Urban Indian programs). There are destined to be other significant changes in the Indian health care landscape. Tribes and tribal organizations with new competencies and capabilities will begin to provide certain functions to IHS direct care programs and regional (Area) and Headquarters offices, instead of the other way around, including some public health functions.

The PHSWG anticipates a healthy mix of public health providers at all levels, involving IHS, tribes, tribal organizations, and partnerships with governmental, academic, and other public and private organizations concerned with public health. These newer relationships appear to be increasing at local and regional

levels. The Director, IHS, has promoted exploration of similar changes at the national level. The more openly and broadly such initiatives are embraced, the sooner tribes, urban Indian organizations, and other tribal organizations will become stronger and able to provide, in concert with IHS, national Indian public health functions.

We affirm that public health responsibility is initially housed at the local level, with additional responsibility located at the regional, as well as national levels. The Workgroup believes that increased tribal and Indian organization leadership in national public health functions is essential. We also assert that no amount of contracting or compacting of IHS services by tribes (even for national public health functions) entirely negates the ongoing Federal responsibility with respect to the health of AI/ANs.

III. RECOMMENDATIONS FOR EACH CHARGE

A. Charges #1 and #2.

Identification of essential public health support services to be provided to direct IHS sites, as well as to compacted and contracted sites that desire to receive these services. Specify ways to ensure the delivery of these services.

To facilitate looking at the Indian health system as a whole, the first two charges were combined to consider both direct IHS sites as well as compacted and contracted sites.

1. The Framework

The PHSWG adopted the DHHS Public Health Functions Steering Committee model of 10 essential public health services. These services were grouped under three core functions that are essential to build the capacity of any comprehensive public health system: assessment, policy development, and assurance.

Assessment focuses on the regular and systemic collection, analysis, and availability of information related to the health of the community, including health status statistics that reflect local, regional and national trends. Assessment includes the following:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, empower people about health issues.

Policy development requires that comprehensive health policies be developed in consultation with the communities served. These policies must reflect current knowledge bases and guide or change local, regional, and national activities, and should affect resource allocation. Policy development includes the following:

4. Mobilize community partnerships and coalitions to identify and solve health issues.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care.

Assurance mandates that constituents are assured access to needed services, often through collaborations, partnerships, and alliances with others. Public health needs must continue to be met even in face of competing concerns. Assurance includes the following:

8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and public health services.
10. Research for new insights and innovative solutions to health problems.

2. Understanding the Service Levels

Local efforts are essential to public health. Public health efforts cannot be successful without local involvement and actions on the community level. These efforts include the assessment and surveillance of local health problems, and the evaluation of the resources needed to respond to them; policy development and leadership training that fosters local involvement; assurance that high quality services are available; informing and educating; and advocacy on behalf of public health excellence.

Areas and/or regions continue to play a critical role in public health support. Responsibilities include collection and assessment of regional health needs, assurance of adequate health activities which can improve health status, support of local capacity building to address disparity in health status, and assurance of services and personnel to meet regional as well as community needs.

National responsibilities include assisting with establishment of nationwide objectives and priorities, assurance of actions and services that are in the public interest, data aggregation, evaluation and information exchange, strong advocacy for necessary resources, and fulfilling Federal obligations to AI/ANs.

3. Public Health Responsibilities at Each Level: The Overall Matrix

The DHHS framework was used to develop a matrix of responsibilities appropriate to each of the national, regional, and local service delivery levels within the Indian health system. This Matrix is Appendix C. Measures of accountability for all levels can and must be developed around these. In this proposed matrix, the regional and national responsibilities are supportive of local public health effectiveness.

The Indian Health Service has historically supported community driven initiatives. This proposed responsibility matrix, and the framework on which it was based, do not suggest radical change from the past. While the PHSWG delineated national and regional responsibilities, the local communities are where appropriate primary public health services are delivered.

For discussion purposes, a detailed staffing projection was developed for the national level. We examined the needs of the regional and local levels, and have submitted proposed staffing needs based upon functions. Further detail about staffing is included in the section on residual.

4. Discussion of Public Health at the Local Level

Public health is an organized process that promotes physical, emotional, social, and spiritual health and prevents disease, injury, and premature death. Local public health services focus on improving the health status of the entire local community, and encompass many disparate activities.

Early public health efforts were primarily focused on preventing the spread of infectious diseases, by ensuring better sanitation, safe drinking water, and other measures. From this, public health has evolved to encompass many and more varied local level activities. All of the following can be considered examples of applied public health principles: provision of non-smoking areas; identification of the source of foodborne illnesses; tracking and controlling outbreaks (such as suicides or hantavirus); promoting healthy lifestyles; and providing preventive services such as immunizations, prenatal care, breast cancer screening, well child care, dental sealants, etc. Public health programs that are working well often go relatively unnoticed. It is when they fail that more attention is generated.

In general, local public health efforts share the following characteristics:

- A focus on prevention as a prime strategy for improving health

- A decision making process that involves collaboration among broad public interests and diverse constituencies
- Intervention strategies and health policies that are based on accurate and timely data and have a grounding in the basic sciences of epidemiology, biostatistics, environmental science, management sciences, and behavioral sciences

There are many new opportunities to strengthen and transform public health at the local level. Improving local capacity for delivering public health services through infrastructure development is critical.

Strategies for Local Public Health System Improvement

1. Develop new partnerships between communities and State health departments to enhance health assessment and planning capacity at the local level.
2. Improve local public health structures and capacities so that the essential public health services can be provided throughout the local level.
3. Utilize community input to help assure a culturally sensitive health care delivery system that is responsive to local needs and the highest local priorities.
4. Integrate prevention activities throughout the community (e.g., workplace, schools, religious groups, and for all ages and genders).
5. Improve accountability and effectiveness through information-based decision making.
6. Protect the public from environmental hazards by developing more proactive interventions.
7. Expand education and training opportunities to increase and improve the public health workforce.
8. Develop a marketing plan to increase the visibility and understanding of public health activities for policy makers and the general public.
9. Build stronger partnerships, including those with tribal governments, to develop more effective public health policies.
10. Provide for increased funding at the local level where the services are actually provided.

Limited resources and staff of local I/T/U organizations often make collaboration crucial in providing local level public health services. Most county or other local health agencies can assist with policy development and some local services such as:

- Health Screening Clinics
- Health Education and Promotion Activities
- Public/Community Health Nurse and Aide/Representative Visits
- Women, Infants, and Children Clinics
- Maternal and Child Health Visits
- Well Child Clinics and Immunization Clinics
- Adult Immunization Clinics

Determinants of Health and the Impact of Public Health

In order to develop healthy local communities, there must be a clear understanding of the major determinants of the general health of the community. High quality health care and many other factors contribute to good health. Some of these determinants are outlined below:

> *Access To, and Quality Of, Health Care Services.* There are many barriers to accessing quality health care in Indian country. Both rural and urban Indian populations tend to be medically underserved. It is well recognized that Indian health care programs are underfunded for the level of needs of their beneficiaries. Even if private sector care is available, it may not be financially accessible, or as culturally acceptable. Most AI/ANs who reside in the urban areas are ineligible for contract health coverage, and frequently have no health insurance. Eligible persons in need of critical public health services such as immunizations, family planning, and well child care may be

unable to access these services simply because there is insufficient transportation or child care available in the community.

Socioeconomic Conditions. There exists a direct relationship between socioeconomic conditions and health status. Poverty, unemployment, and lack of education have often been associated with the poorer health status of Native American people. Through data collection and analysis, public health professionals can help identify and report socioeconomic problems adversely affecting health, as well as address obstacles to obtaining care.

The Physical Environment. Studies have documented the impact of outdoor and indoor air quality, safe drinking water, cleanup of hazardous waste sites, and food protection on the overall health of individuals in the community. Public health is responsible for examining and reporting the impact. The public health system has an environmental component that is responsible for things such as water quality, food safety, radiation protection, sanitation, and control of toxic substances.

Lifestyle/Behavioral Risk Factors. The health of an individual and a community is greatly influenced by behavioral risk factors, including tobacco use, alcohol and other substance abuse, physical activity, and diet. Public health impacts lifestyle in two ways: 1) by analyzing data to identify the nature and extent of the risks, and 2) by providing programs that promote healthy behaviors.

Local Public Health Involves the Whole Community

Since a broad range of factors influence health, many public and private entities can play a positive role. Health care providers, public health agencies, hospitals, and community-based health clinics all have a direct impact on the local public health. In addition, many government agencies, community organizations, private industry, schools, social service, housing, transportation, religious organizations, have an integral role in the overall health of the community.

Communities that are successful in improving health involve all of the major stakeholders and work to coordinate their roles and responsibilities. They also have a common understanding of the multitude of determinants of health and ways to accommodate diversity in values and goals.

5. Discussion of Public Health at the Regional Level

Both in general, and at times of unusual public health occurrences in one or more communities, there must be a close cooperative relationship with regional staff to support local officials and health care delivery personnel.

Regional Roles: Supporting Local Public Health

Some diseases and health conditions have been conquered by modern advances (vaccines, antibiotics, sanitation improvements), but new ones constantly emerge (AIDS, hantavirus), or increase in prevalence (Type 2 diabetes), and/or reemerge (periodic measles and plague epidemics). Responses or approaches to AI/AN health problems that span multiple tribes/service units are best designed regionally or nationally. For the best in AI/AN health care, staff must be prepared to deal with an uncertain future, and regional public health support is vital to this goal.

Similarly, regional public health support is critical in times of public health emergencies. Prepared, experienced staff whose primary concern is AI/AN health best provides this assistance. The public health competencies needed in a public health emergency are rarely all available at just the local level. Assistance is often needed from other seasoned public health professionals, such as from State and

County governments, and the Centers for Disease Control. However, AI/AN health is not their primary focus, making additional regional public health support from Indian health care professionals critical.

What Regional Public Health Expertise Can Provide

Regional approaches to public health problems should be expected in part to produce the following types of anticipated outcomes.

1. Surveillance activities for early identification of health problems which have proven in the past to involve multiple local facilities.
2. Coordination of culturally sensitive inter-facility response teams in the event of a large outbreak in a particular geographic location.
3. Rapid response to outbreaks.
4. Coordinated approaches to health education/public relations efforts.
5. Facilitation of multi-community based health care provider education/training.
6. Coordinated efforts at inter-facility transfer of patient specific health information.
7. Avoidance of duplicative community based interventions, policy development, and other activities when a regional approach could be more cost effective.

Effective regional public health support for each of the ten public health essential functions requires a variety of competencies that cannot realistically be expected to be present in adequate supply in all local health settings. Examples are statisticians, epidemiologists, and data managers. As reflected in the responsibilities matrix (Appendix C), these professionals shoulder multiple responsibilities. They not only carry on the day to day regional public health functions, but they also represent a pool of experienced staff that can be called into action on an as needed basis for significant, but infrequent, occurrences unique to specific communities. Many have clinical experience, and are capable of handling multiple types of events (e.g., communicable disease outbreaks, occupational health related events, hazardous material related events in communities, etc.). They also are in a position to inform and educate, and to provide a variety of support for public health functions which need to involve multiple communities.

Within the public health infrastructure necessary to improve the health of AI/ANs, advocacy is central to the national role, and service delivery is central to the community-based role. "Support of local efforts" should be the theme central to the mission of regional public health entities. Regional entities are vital cogs in both national advocacy efforts as well as to community-based program implementation activities.

6. Discussion of Public Health at the National Level

IHS is first and foremost a public health agency. Despite this fact, it is the national level of Indian public health functions that has been most questioned as necessary, and most threatened by downsizing and constrained resources. The PHSWG has considered this to be the greatest vulnerability of the Agency in attempting to carry out its mission. A reaffirmation is needed of the commitment of IHS, at the highest levels, to engage in and be supportive of Indian public health.

What National Public Health Expertise Can Provide

A national approach to public health problems should be expected, in part, to produce the following types of anticipated outcomes:

1. Advocacy with other Federal agencies, academic institutions, professional organizations, and private foundations to include health data that is relevant to AI/AN people.
2. Collaboration with national and international agencies, academic institutions, professional organizations, and private foundations to provide resources in response to identified health problems

that include multiple States, cross international boundaries, or affect a majority of the AI/AN population.
3. Coordination of culturally sensitive responses in the event of a national or international epidemic or border health issues.
4. Sharing of health data to inform congressional members and committees of the funding needed to improve the health status of Native American communities.
5. Coordinated approaches to widespread chronic health problems, like diabetes, that affect many Indian communities.
6. Facilitation of executive directives that promote public health practices and improve the health status of Indian communities.
7. Avoidance of duplicative community based interventions, policy development, and other activities when a national approach could be more cost effective.
8. Facilitate transfer of information between local, regional, and national centers

Dedication of Resources Is Required

Public health responsibilities at the national level demand certain public health competencies. Some are required to help fulfill the Federal government's ongoing obligations to AI/ANs, and/or are required by law to be carried out by Federal officials (see discussion of "residual" public health functions later in this report). These are relatively small. The majority of the national functions can be carried out by either IHS, tribes, and tribal or Indian organizations possessing the necessary competencies. However, this requires that adequate resources be preserved for these purposes. Relationships with other external partners must be developed to ensure collaborative efforts. However, it is unreasonable to expect such partners to bear most of the AI/AN public health burden at the national level. It will be important that we dedicate Indian health care resources to these necessary functions, regardless of the mix of IHS, tribal organization, and other public health providers involved.

Essential Public Health Services at the National Level

The following brief scenarios are reflective of the public health support required at the national level for each of the 10 essential public health services.

1. Monitor health status to identify common health problems.

   Information is critical for any public health system. The collection of pertinent data in a unified fashion is essential to enabling Indian health care systems and the Agency to be in a position to elevate the health status of AI/ANs and their communities. National leadership is required in both the aggregation and interpretation of Indian health care data.

2. Diagnose and investigate health problems and health hazards in the community.

   Collaboration is a critical component of these services. This collaboration must involve local, regional, and national services. National services are necessary to ensure adequate responses to critical national, regional and local needs.

3. Inform, educate, empower people about health issues.

   National responsibilities for this function are dependent upon interpretation of needs from local and regional sites, as well as interagency interactions. National involvement focuses on IHS's relationship to Congress and other Federal Agencies, as well as academic institutions and philanthropic foundations. Well-substantiated funding requests and demonstrations of the efficacy of public health practices are required.

4. Mobilize community partnerships and coalitions to identify and solve health issues.

   The establishment of partners at a national level results in increased leverage of funding and identified resources. Successes learned at a national level can be replicated at regional and local

levels, and vice versa. Both monitoring systems and policy formulation at the national level can be enhanced through collaborative relationships. In addition, concerted efforts can ensure fewer duplicative efforts, increasing resources for the remaining services. Adequate organizational structure is required to ensure fiscal and human resources from diverse organizations can be melded together in a cohesive and effective manner.

5. Develop policies and plans that support individual and community efforts.

   Efforts and policies created at a national level must help ensure that I/T/U public health concerns are supported by Agency actions. In addition, strategic planning can use public health concerns as a basis for prioritizing goals and directing legislative initiatives.

6. Enforce laws and regulations that protect health and ensure safety.

   The Indian health care delivery system is not a law enforcement agency. However, our involvement with the developing of Federal laws and regulations that may impact directly on the provision of public health or on health status of Indian communities is beneficial. For instance, mandatory arrest in domestic violence cases has been shown to decrease associated morbidity and mortality. Assistance in development of model laws, or distribution of best of practice prototypes can result in protection of health and improved safety.

7. Link people to needed personal health services and assure the provision of health care.

   There continues to be a significant gap between the needs and funding levels. Public health systems rely on adequate individual access to care. When shortfalls exist, the Agency should assist in measuring them, and advocate for remedies to address them.

8. Assure a competent public health and personal health care workforce.

   IHS has made professional competency a high priority. This has tremendous impact on the day-to-day care that individuals receive in the health care setting. Ongoing activities at the national level help ensure that public and personal health care is available and appropriate. Moreover, inclusion of public health issues in leadership training will result in continued and improved recognition throughout the Agency and Indian country of the importance of public health.

9. Evaluate effectiveness, accessibility, and quality of personal and public health services.

   These kinds of evaluations are critical to building the public health capacity of the Indian healthcare system and can help improve health status for individuals and communities. Appropriate outcome measure selection can ensure that significant public health issues receive adequate emphasis in the health care delivery system.

10. Research for new insights and innovative solutions to health problems.

    Research invites the Indian health care delivery system to identify new approaches. Research policies help ensure that tribes are adequately represented in the review process, and are able to maintain appropriate control over the research process. Moreover, research findings may be the basis for new funding, and introduce innovative programs to augment the current healthcare system.

7. Recommendations

1. Develop an IHS special general memorandum for Dr. Trujillo's signature. This memorandum should reaffirm that the Indian Health Service is first and foremost a public health agency that is committed to devoting available resources as well as pursuing the additional resources necessary to assure that Indian people enjoy the benefits of public health.
2. Formally adopt by publishing in the Federal Register the Mission and Goal proposed in *Design for A New IHS*, the final report of the Indian Health Design Team. Namely:

   MISSION: The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

   GOAL: To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people.
3. Preserve, by setting aside for that purpose, adequate resources for carrying out essential national Indian public health services and responsibilities, whether performed directly by the Agency, or by other capable organizations. The current Workgroup has proposed a minimum number of positions that must be provided to carry out these essential national public health functions.
4. Continually strive to structure regional and national public health efforts in a manner designed to be maximally supportive of local public health activities and needs.
5. Increase the number of I/T/U sites that can provide continuing education and training to improve performance of the essential public health services, by financially supporting development of Indian public health training modules appropriate for administrative leaders, clinicians, and other staff. Make these modules easily accessible, e.g., via the Internet, and provide CEU, CME or other certificates of completion.
6. Specify in the scope of work of the Epidemiology Centers that they, in consultation with the tribes they serve, develop a plan through which local Indian public health infrastructures can be strengthened. The plan would identify resources required beyond those currently available to the Epi Centers.
7. For Areas not yet served by an Epi Center, Headquarters should actively encourage Area or multi-Area assessments and prioritization of their unmet public health support needs. Headquarters should designate this as a residual public health function to assist in advocacy efforts.
8. Stimulate the development and use of model public health codes of various types by identifying a number of such tribal codes already in use. With the tribe's permission, make these codes more readily available to others.
9. Encourage local, regional, and national leaders to increase public health competencies for their facilities. Techniques for accomplishing this might include incorporating specific public health competencies in their personnel position descriptions and evaluations.
10. Incorporate specific efforts designed to improve public health competency and awareness into Indian health care leadership training. The Epidemiology Centers and others may be used to help provide this public health direction and assistance.
11. In order to create and strengthen critically needed public health support entities outside of IHS, seek FY 2001 appropriations to more fully fund all four (4) existing Epidemiology Centers (to a level of $500,000 each per year). Additionally seek FY2001 funding for eight (8) more Centers (to a level of $500,000 each per year), thereby establishing one Epidemiology Center in each of the 12 Areas as was the original intent. Other entities should also be considered for public health funding.

B. Charge #3.

Identification of essential public health data necessary for IHS to perform advocacy and other core functions and how to ensure that this data will continue to be accessed from all delivery sites.

1. Why Is Data Important?

Access to meaningful and important information is a critical requirement for any public health system. Without it, an individual, community, tribe, or nation cannot know where they are, where they need to go, and if or how well they are getting there. In addition, there are, and will continue to be, innumerable reporting requirements from our various funding sources, public and private. If we are to continue as a public health system for AI/ANs, the Indian health systems must maintain the ability to gather, compile, analyze and report essential information.

Information is critical at all levels of our systems – local, regional, and national. Information is needed to direct public health initiatives at each of these levels. Although the Workgroup's charge from the ELG (and therefore this response) focused on advocacy needs at the national level, IHS success at the national level will depend upon our maintaining an entirely adequate information infrastructure at the local level. Without robust systems and support at the local level, it is unlikely that we will have accurate or meaningful data to aggregate and analyze at the national level. It is beyond the scope of the Workgroup to make specific recommendations on the creation and maintenance of local infrastructures; however, these are absolutely essential.

The PHSWG chose to focus on patient based data that could be aggregated in a national dataset to provide the information needed for national level advocacy and leadership. It is clear, though, that community-based and likely regional data (such as air and water quality, sanitation, the availability of educational programs or employment opportunities, community immunization levels, etc.) are also important public health data. Although a detailed enumeration of these additional community and regional data elements is beyond the scope of this Workgroup, it is important that this is done in close collaboration with the appropriate disciplines and other public and private organizations. Appendices D and E illustrate some indicators that also could be tracked to monitor the health status of a community.

2. Data Collection Challenges

IHS's continuing ability to compile a minimally sufficient aggregated set of information at the national level over the next several years faces a number of challenges. These include:

1. There is no legal authority to require that tribal and urban programs share data with IHS. IHS must negotiate the sharing of data on a tribe by tribe, urban by urban basis.
2. The variety of clinical, administrative, and financial applications and systems at the local level is likely to increase significantly over the next several years.
3. How data is locally collected will vary widely (as the Baseline Measures Workgroup discussed in their report), so some of the data will likely become less uniform and more challenging to accurately aggregate.
4. Defining data items needed for a nationally aggregated data set(s) is a moving target. Our needs today, will not be the same as our needs tomorrow, or the day after that. We need a process that accommodates constant change.
5. IHS programs, tribes (both those who have chosen to 638 and those who have not), and urban programs will likely want clear descriptions of what data is needed at a national level and why. We will have to justify each data element, especially the most sensitive ones.

6. Individual tribes and urban programs may want to pick and choose: e.g., one may be willing to share data for GPRA needs, but not for ORYX; another for the Trends books but not for ad hoc HQ performance monitoring; yet another for national epi surveillance, but not for immunization monitoring; etc. Thus we need to be able to identify "sets within sets," rather than just one uniform set.
7. Some of these "data needs" are already well defined and have already actively involved tribes and urban programs in their development (e.g., the new diabetes moneys, tribal epidemiology centers, etc.). Others are poorly defined and/or have had little T/U involvement in their development (e.g., advocacy for AI/AN needs by IHS on "behalf" of tribes and urban programs).

To best address these challenges, the PHSWG developed a data matrix that maps the initially recommended minimal data elements to specific reporting requirements and/or advocacy needs. This matrix is Appendix F. We recommend that this method be used to maintain and update a list of minimal data elements and to serve as a basis to negotiate reporting agreements with tribes and urban programs.

More I/T/U systems currently use the RPMS information system than any other single, integrated system, so the Workgroup chose to focus on the data elements already included within RPMS in defining this minimal data set. However, this proposal is not limited just to RPMS. The elements we specify should be contained in any other, reasonably proficient, clinico-administrative system. The PHSWG recommends that any future national repository accept data from all systems as long as it is transmitted to it in an acceptable, standardized format and transmission protocol, as is currently done by the IHS Data Center.

The Workgroup developed an initial list of data elements that, at this one point in time, we would need to provide effective national level advocacy and meet current reporting requirements. More importantly, we propose a mechanism for periodically updating the list to meet the needs of inevitably changing requirements. The PHSWG recommends that the responsibility for maintaining this list for all Indian health systems be placed within the scope and the role of the Information Systems Advisory Committee (ISAC), a standing consumer advisory group to the IHS's Division of Information Resources.

3. Recommendations

1. Use the attached data matrix (Appendix F) that links a minimal set of required data elements to specific reporting requirements and/or advocacy needs to serve as a basis to negotiate reporting agreements with tribes and urban programs.
2. The responsibility for maintaining and updating this list for all Indian health systems should be placed within the scope and role of the Information Systems Advisory Committee (ISAC), a standing consumer advisory group to IHS's Division of Information Resources.
3. Ensure that future national repositories must accept data from all systems as long as it is transmitted in an acceptable, standardized format and transmission protocol.
4. Ask ISAC to evaluate the best way to display data from a public health perspective; incorporate a public health perspective into ISAC decision making by ensuring adequate clinical and public health representation on this committee
5. Provide adequate funding to support a national tribally run data project (e.g., see Appendix G for examples).
6. While assuring data security and confidentiality of *individual* information, explore ways that improved epidemiological information could be obtained through data sharing with other data repositories.

7. Promote and encourage increased on-site local access to data via online information systems. Demonstrate and advocate the benefits of improved connectivity to the local facilities responsible for funding these improvements.
8. Direct (and financially support) the development of an Indian public health Web site linked to the Indian Health Web Site. Assign responsibility for ongoing content maintenance and improvement to a specific entity or individual while ensuring that adequate clinical input is available.

C. Charge #4.

Recommend models for providing public health services to AI/AN people using a collaborative and integrative approach with other organizations

Changing patterns of morbidity and mortality among AI/ANs, and changing root causes of these, require newer approaches to be successful at elevating health status. At the same time, evolution of the Indian health care landscape is bringing new opportunities to broaden Indian public health responsibilities beyond the sole purview of the IHS, inviting new partnerships and collaborations from the local to the national levels.

1. Changing Patterns of Morbidity and Mortality

The overall health of AI/AN people has improved over the past several decades, with significant improvements in infant mortality, life expectancy and the control of infectious and communicable diseases. This success has been achieved primarily through improved access to quality medical care and aggressive public health measures, including improved housing and sanitation. However, it is clear that other, more chronic and unique health problems are dramatically emerging, the extent and severity of which appear specific for AI/AN groups. Type II Diabetes Mellitus has become a problem of epidemic proportions among Native Americans. End stage renal disease is developing in some tribes at a rate almost nine-fold faster that the general U.S. population. Coronary artery disease, previously thought essentially non-existent in Native Americans, is rapidly becoming a major source of morbidity and mortality. While mortality from this disease has plummeted among the general U.S. population by over 50% since 1968, heart disease has become the number one cause of death among Native Americans.

Such changes in the patterns of morbidity and mortality, along with their root causes which now involve behavioral risk factors to a much greater degree than previously, call for new approaches to monitoring community health status, data collection, involvement of tribes, interventions, and advocacy.

2. New Opportunities for Partnerships and Collaboration

Evidence collected by the PHSWG, as well as examples of specific projects, suggest that development of strong public health partnerships is already underway. What is more, this development is at a point where additional attention and active support by the IHS could be critical to helping pave the way to an Indian public health future involving much broader involvement and leadership by tribes and tribal organizations, along with their IHS and non-IHS partners.

To be successfully supportive, IHS must be willing in some cases to pass the responsibility *and* the necessary resources for national and other public health functions, into the hands of others. At the same time, IHS as a public health entity must continue to safeguard to an appropriate degree the adequacy of its own public health capabilities, to assure tribes they will have a strong Federal public health partner and advocate, and to assure the carrying out of ongoing Federal obligations with respect to the health of AI/ANs.

In response to its fourth Charge, the PHSWG collected and examined examples from many existing programs having already successful or very promising efforts emphasizing collaboration for the delivery of public health services. There are, no doubt, many other such efforts in progress, but these were ones readily accessible to members of the Workgroup over a short timeframe. A brief synopsis of some of these examples is included as Appendix G.

The new Epidemiology Centers are emerging strengths of the Indian health care system, holding great promise, and showing early signs of significant progress. Universities, in partnership with tribes and the IHS, can provide leadership, expertise, and focus to Indian public health activities, as evidenced by the University of Arizona's successful Center for Native American Health. Tribally supported organizations, such as Area Health Boards, Northwest Indian Health Board, and the National Indian Council On Aging (NICOA), can and do contribute in significant ways to the current, interwoven AI/AN public health fabric. Other examples also may be found in Appendix G. In the view of the Workgroup, IHS must strive to strengthen such efforts, and seek opportunities to transfer some of the national public health responsibilities and resources to them as increased competencies develop, in the interest of providing the best public health services possible for the future.

3. Factors for Increasing the Success of a Public Health Program

Though the examples collected of public health models emphasizing collaboration are varied in circumstances, funding, partners, etc., there are nonetheless common elements between these varied models. The PHSWG identified some of the similarities that lead to successful implementation of a variety of community initiated public health programs. These elements have been fashioned into a template of factors to consider, serving as a guide in efforts to maximize the potential success of new programs (below). For convenience of use, this template is also included separately, as Appendix H.

Factors for Success	**Organizational Involvement**				
	Tribal	***Health Care Providers***	***Local Community***	***State/National***	***Non-government***
Baseline Needs Assessment					
Consultation Process					
Plan Based on Public Health Principles					
Communication Network					
Funding Resources/ In-kind Services					
History of Collaboration					
Process for Coalition Building					
Inclusion of All Shareholders					
Evaluation Plan					

4. Recommendations

1. Distribute the full report of the PHSWG, making available CEU and CME, to as many Indian health care programs as possible. This will demonstrate the resolve of the Agency to renew and strengthen its central focus on public health of Indian communities, while at the same time providing stimulus to strengthening local public health capacities and increasing collaboration.
2. Make 'best of practice' models and information about funding, resource availability, and evaluation available for tribes and other interested groups. This would include disseminating templates such as Appendix H for improved success of new programs to I/T/U shareholders. Ensure that this information remains current by designating a clinical point of contact to provide content management, similar to the *Provider*.
3. Support distribution and implementation of current community health assessment models. (See Appendix G for an example of a community health profile instrument.) Identify and make resources available for technical assistance and training so that Indian communities can utilize successfully these instruments to document and monitor their overall health status.
4. Promote existing information clearinghouses by identifying and linking to the IHS Web site and the proposed Indian public health site (see Charge 3 Recommendation #7 above). These linked sites would include national epidemiological data, successful programs in prevention and public health and

technical assistance to and support of tribes, urban Indian Centers and the regional Epidemiology centers throughout the nation.

5. Increase active steps to foster national Indian public health leadership capabilities in interested Indian organizations (for example, the Epidemiology Centers, the NICOA Data Project, and the Center for Native American Health). Establish effective partnerships with universities and other public and private entities.
6. Use existing IHS evaluation proposal funds to specifically strengthen public health infrastructures at the local level, including making funding available to non-IHS organizations with an Indian health focus that can assist with this capacity building. Evaluate the improved health outcomes that result from this improved public health infrastructure.

D. Charge #5.

Develop a plan to assure the provision of adequate public health support within the expanded managed care environment.

The PHSWG adopted the IHS Managed Care Committee definition for managed care. "Broadly defined, the term 'managed care' represents a diverse set of strategies and mechanisms for managing health care costs, quality, and utilization, such that additional high quality care can be provided." (From *Managed Care in the Indian Health Service: Successful Strategies for Increasing Health Care Quality, Accessibility, and Economy for American Indians and Alaska Natives,* May 1991.)

1. Indian Health Care and Managed Care: Similarities and Differences

Managed care coordinates and assumes financial responsibility for the clinical care needed by a defined population. Historically, the Indian Health Service has been in a similar role, utilizing some of the same tools employed by managed care organizations (MCOs), such as preauthorization requirements for Contract Health Services. Indian health care systems have built-in cultural competency advantages for delivering healthcare in Indian country, but there are also other significant differences.

The most significant health care delivery systems must ensure that three needs are met:

- delivery of health care to individuals,
- health data collection and information exchange, and
- community interventions and policies.

The I/T/U Indian Health care programs have operated using a community oriented primary care (COPC) model, assuming broader responsibilities than specific health care services to individuals. Commonly, services directed at communities are part of the mix of services provided by Indian health care entities. It is within this context that issues concerning adequate public health support within a managed care environment arise, particularly as this environment begins to more heavily influence the day to day conduct of clinical practice in Indian health care settings.

A variety of needs and factors have led to Indian health care systems being more public health oriented than most. These include: rural isolation requiring special approaches to access, extreme health disparities compared to other populations, a lag in appropriate sanitation facilities, living conditions prone to outbreaks of serious disease, shortages of needed medical and surgical care making prevention all the more critical, etc. Managed care organizations did not arise in settings with these challenges, and their penetration of and interest in such markets remains extremely limited.

Nonetheless, operation of I/T/Us has become more dependent upon third party collections compared with available Federal appropriations, and with this comes some degree of transference of the insurer's business practices. Typically, the public health elements so essential to adequate care of AI/ANs in either rural or urban settings are not reimbursable as specific services, nor are they adequately incorporated in the capitation schemes of prospective payors. Dependence on collections from third party insurers carries with it an underlying threat to the provision of adequate public health services.

Critical functions that are not usually performed as well by MCOs include epidemiological data collection, disease surveillance, health promotion and education, and other interventions at the community level. Motivation in the managed care sector tends to be (though certainly not exclusively) based on financial health and performance, while the focus of COPC is on improved health status of a community. Health plans that are primarily for profit may fail to engage in some public health activities due to shorter term financial concerns.

The need for regional and local public health support has not decreased in an era of HMOs, PPOs, and other replacements for independent fee-for service/practitioner office situations. For example, as reported in *AMA News* (December 14, 1998), involvement of public health departments was essential in attempts to track down hundreds of homeless people exposed to 5 patients with tuberculosis who had all stayed in the same homeless shelter. HMOs and insurance companies do not have pursuing public health interests as their primary mission, unless they relate directly to their specific covered population.

2. Interfacing With Managed Care

It is reasonable to expect that managed care will have an increasing impact on some communities that traditionally received services through I/T/U models. Being both covered by a managed care plan and eligible at an Indian health care site is already becoming much more common. What used to be unified health records are increasingly split between health care organizations, affecting both patient care continuity and the ease of community surveillance for public health purposes. And, the relative importance of different data elements may vary, due to different basic motivations.

Early experience has shown that traditional Indian health care and MCOs are not exactly a "natural fit", and require significant effort to begin to interface effectively. The unique nature of health care provision to AI/ AN populations has been previously addressed during the IHS Managed Care Roundtable, and the NIHB Managed Care Project. These results are available in their publications (included in the attached bibliography, Appendix J).

The IHS Roundtable concluded that the participation of Indian health programs in managed care either as providers or health care plans is fraught with potential problems. In some regions, provider network formation may be difficult for tribes to achieve. In addition, Indian health programs do not routinely have access to enough capital to remain competitive in a market place. Payment to I/T/U facilities may be capitated or non-capitated, and may not be proportionate to the scope of services provided. Finally, the 'case-mix' of many AI/AN communities may be far more medically complex, reflective of higher disease burdens in Indian communities, and require more intensive public health measures -- yet available capitation amounts may not take this into account.

Nonetheless, there are areas of mutual concern between Indian health care and managed care organizations, especially when there is overlap of patients. Both personal health information (with appropriate patient privacy considerations), and also community health information could be shared in meaningful ways. For example, it should be highly advantageous to an MCO to share information specific to its AI/AN members as a group, if that was to be used, for instance, by a tribe or an Epi Center to launch a public health intervention that could improve the health of that portion of the MCOs enrollees. This could only increase their profits ultimately. And all that would be necessary for this would be to work out the details of transferring information without patient identifiers between organizations for the

group of patients of interest. This is already feasible, and already being tested by one of the Epi Centers with other repositories of health data.

Increasing pressures to document performance through outcome measures are affecting I/T/Us and MCOs similarly. GPRA measures for government accountability, ORYX measures for public and private hospital accreditation, and HEDIS measures for MCO comparisons, have many similarities. In some ways, Indian health care has advantages of longer term involvement with clinical outcomes measuring, well before any of those particular terms were invented, or MCOs were expected to track such data. I/T/Us experienced with monitoring clinical objectives outcomes bring that as a strength when negotiating with other health care entities. Active involvement with public health efforts is no doubt another strength, if trends toward individual consumer and community pressure for publically available outcomes data continue. At the same time, MCOs may be able to offer Indian health providers insights on how to improve efficiency, patient flow, patient satisfaction, or otherwise improve functioning.

MCOs having had limited contact with Indian health care systems may be totally unaware of their public health strengths, their clinical objectives experience, their accreditation status, their special solutions for providing care in Indian communities, etc. What is more, they may mistakenly believe that Indian health care is the exact opposite of managed care, because there are no premiums, no copays, no deterrents to overutilization, no safeguards to control costs or limit visits. But those who have been involved with Indian health care see it differently. Given a chance to communicate this, they point out that it's a system with a fixed amount of dollars available to serve a given population, that care must be rationed, using preauthorization measures and retrospective review of emergency care, that pharmacy formularies are in use, and that instead of excessive visits, the problem is often inadequate availability and accessibility to provide the *expected* number of visits. Increased communication could reduce such misunderstandings.

3. Recommendations

1. Assure appropriate costs for necessary public health activities are added into any measures of "level of need funded" (LNF) or of any capitation amounts determined as appropriate for reimbursement of Indian health care services. It is the PHSWG's understanding that the current LNF Workgroup is addressing this matter.
2. Include health care economist and heath actuary position in the mix of types of staff needed to help carry out essential public health functions
3. Request that the IHS Managed Care Committee begins to nurture mutually beneficial relationships with organizations such as managed care trade associations and the National Committee for Quality Assurance.
4. Encourage IHS Areas to identify successful approaches in reaching agreements with third party insurers who cover significant numbers of AI/ANs, in order to obtain epidemiological significant information for mutually beneficial purposes. The managed care committee should develop a prototype and encourage areas to pilot a process that will identify and make available this new effort.
5. Create a mechanism that will enable best public health practices in Indian health care settings to be readily shared, either on the internet or the IHS intranet, including a ready means to obtain approval of new content, and to promptly publish electronically.

E. Charge #6.

Comment on whether there would be any "residual" public health functions at IHS Headquarters in a hypothetical 100% Self-governance compacted environment. If yes, what are the functions and estimate the resources needed.

In December 1998, the Workgroup received an informal request (a sixth charge) from the Indian Health Leadership Council (IHLC) to amplify its original scope by making recommendations to the Internal Evaluation Team (IET) regarding any potentially residual public health functions within IHS Headquarters in a hypothetical 100% self-governance environment. The Indian health care landscape has been changing. Tribes and tribal organizations with new competencies and capabilities will begin to provide certain functions to IHS direct care programs and Area and Headquarters offices, instead of the other way around, including some public health functions. The Workgroup not only welcomes, but deems as essential, increased tribal and Indian organization leadership in national public health functions.

Nonetheless, it was the conclusion of the PHSWG that a small amount of residual public health responsibilities and functions would remain, even in a 100% compacted environment. Using the responsibilities matrix developed as the basis for this work in Charges 1 and 2, the PHSWG identified the necessary national, regional and local services and type of staff to meet each role, as well as our determination of the public health residual. The resulting table is located below.

1. Assumptions/Conditions

The PHSWG is proposing this mix as the absolute minimum functional staff required to maintain this infrastructure at the national level, while recognizing that IHS remains underfunded to fully carry out its mission and goal. In order not to be misinterpreted, these recommendations must be considered only in conjunction with the following assumptions and conditions.

1. Indian Health Service will continue to exist as an organization within the Federal government.
2. All tribes will have taken all of their public health shares for the local, area, and HQ operations.
3. Indian Health Service will continue to report to other parts of the Federal government in behalf of its component parts, including tribal and urban programs.
4. Current reporting requirements, as well future undefined and unanticipated requirements, will apply to all Indian health systems - IHS, tribal, and urban programs.
5. Because of the likelihood that requirements will change, the residual is dynamic.
6. An information resource entity will provide the information infrastructure necessary to support Indian Health Service reporting requirements, as well as local program information system needs. Staffing for this was not included in this analysis.
7. These staffing projections are based on "proxy FTEs." With the exception of the portion of the staff designated as "residual," which must be Federal employees, proxy FTEs refer to actual Federal staff, or funds to support contracted staff, or their equivalent. Residual FTEs alone would not be sufficient, in and of themselves, to perform all legally mandated functions, (i.e., some functions are required by law to be performed, but the law does not require that Federal employees perform them), and otherwise meet the minimal national level of public health responsiblities.
8. The Workgroup did not look at personnel, contracting, executive direction and/or management, EEO, or support staff, support of Federal presence, or overall budget formulation; the Workgroup did not look at the OMB 876 list to determine what are public health functions. The Workgroup assumed that this was done by the IET.

9. Proposed DFEE staffing does not include facilities planning, construction, M&I, or sanitation construction (86121); These needs should be earmarked and are project dependent
10. Certain programs, like the special initiatives (diabetes grants/ CDC epidemiologists, Indian children's program) are extra or add-ons; the Workgroup assumes that the money for these programs and the needed support structure is within the special appropriation. These needs are not included in our estimate of public health staffing.
11. Buy backs were not included in these minimal numbers.
12. Training requirements for the remaining national staff were not included in these numbers.
13. Y2K needs are not addressed in this proposal.
14. Accreditation support is not included at the national level.
15. These recognized needs were then imposed upon the current organizational structure, though the Workgroup is choosing to defer comment on the organizational structure.
16. The senior public health consultant is a position with cross cutting expertise, based on skills and experience.
17. Some of the epidemiologists are medical epidemiologists because of the nature of our health organization.
18. There may be a need to consider research dollars in the form of grants in the future—to help ensure that the needs of the populations are met in novel and creative ways

2. Residual Summary

Based on the above assumptions, the PHSWG identified the *absolute minimal* number of proxy FTEs necessary to meet the agencies public health needs, assuming that other outside resources will be available for public health (e.g., private foundations, public and private universities, regional Epi Centers, an independent institute of Indian health, etc.).

	NATIONAL		REGIONAL	LOCAL
FUNCTIONS	**Type of Staff**	**# FTEs**	**Type of Staff**	**Type of Staff**
1. Monitor health status to identify community health problems.				
	medical informaticists	5	data manager	data manager
	data managers	4.5	epidemiologists	
	epidemiologist	1	statistician	
	statistician	1		
	public health advisor *	2		
2. Diagnose and investigate health problems and health hazards in the community.				
	data manager	1	epidemiologists	PHN
	medical epidemiologists	2	statistician	environmental health specialists
	epidemiologist	2	PHN	
	statistician	1	environmental health specialists	
	environmental health specialist	2.5		
3. Inform, educate, empower people about health issues.				
	public health advisor *	4	public health advisor *	public health advisor *

FUNCTIONS	NATIONAL Type of Staff	# FTEs	REGIONAL Type of Staff	LOCAL Type of Staff
4. Mobilize community partnerships and coalitions to identify and solve health issues.				
	director	1	public health advisor *	public health advisor *
	senior public health consultant	1		CHR
	public health advisor *	3		PH nutritionist
	deputy director/ intergovernmental affairs	1		
	budget analysts	2		
5. Develop policies and plans that support individual and community health efforts.				
	public health advisor *	5.5	public health advisor *	PH Advisor
	health planner	1		
	health policy analyst	1		
6. Enforce laws and regulations that protect health and ensure safety.				
	attorney	1	attorney	attorney
	public health advisor *	1	sanitarian	sanitarians
			public health advisor *	
7. Link people to needed personal health services and assure the provision of health care.				
	public health advisor *	2.5	health care planner	Executive Committee **
	engineer	1	public health advisor *	
8. Assure a competent public health and personal health care workforce.				
	recruitment	2	CMO	site manager
	information specialist	1	recruitment	QA director
	QRP (health professional & paralegal)	3	public health advisor *	patient advocate
	public health advisor *	6		AdHoc group ***
				recruitment
9. Evaluate effectiveness, accessibility, and quality of personal and public health services.				
	Organization Performance Team		public health advisor *	site manager
	public health advisor *	10	epidemiologist	QA director
	epidemiologist	1	medical informaticist	patient advocate
	data manager	1		AdHoc group**
	statistician	1		
	medical informaticist	1		
	health economist	1		
	health actuary	1		
	business officer consultant	1		
10. Research for new insights and innovative solutions to health problems.				
	IRB and Research	4	IRB	health planner
Total FTEs		**80**		
Residual		***12***		

Assumptions and operating definitions

National = HQ

Regional = Area There are 12 Areas.

* *Public health advisors are defined as individuals with public health skills that will benefit the program (e.g. public health nursing; nursing; physicians; mental health; sanitarians;engineers; epidemiologists; MPH training individuals; etc.). See Appendix I. DFEE Public Health Functions*

** *Represents health director, business mgt, medical director*

*** *Executive Committee + (PHN, nutritionist, tribal medical director, sanitarian, engineer, Head Start, behavioral health, community health, business office, Governing Board, health administrator, and appropriate community/tribal members)*

APPENDICES: See Appendices Document

Appendix A: Workgroup Chronology and Background

Appendix B: Surveys

Appendix C: Public Health Responsibilities Matrix

Appendix D: Data Needs for Environmental Health Services and Sanitation Facilities Construction

Appendix E: Community Health Report Card

Appendix F: Uniform Set(s) of Nationally Aggregated Data

Appendix G: Examples of Successful Public Health Activities

Appendix H: Factors for Success Matrix

Appendix I: DFEE Public Health Functions

Appendix J: Bibliography